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CALENDAR FOR 2005 MA AND MEDICARE COST PLAN RENEWAL PROCESS
(Including the Medicare Drug Discount Card Program for Exclusive Medicare-Approved Card Sponsors)

2004	
June 11	• CY 2005 ACR, Plan Benefit Package (PBP), and technical instructions become available for download from the Health Plan Management System (HPMS).
June 23-24	• CY 2004 Adjusted Community Rate Proposal (ACRP) Seminar.
June 30	• CMS distributes CY 2005 Summary of Benefits instructions to the industry. • Call Letter conference call, see cover letter for details.
July 2	• CY 2005 ACR/PBP Pre-Upload Validation (APV) tool becomes available for download from HPMS.
July 25	• Final date for Medicare Advantage organizations and Medicare cost plans to submit **CY 2004** marketing materials for CMS's review and approval. Note: This date does not apply to CY 2004 file & use materials since the organization may file these materials with the CMS Regional Offices 5 calendar days prior to their use.
August 2	• CMS begins accepting CY 2005 ACRPs via HPMS. • CMS begins accepting CY 2005 marketing material for review, including Drug Discount Card Program marketing materials, ANOCs, and SBs. (Note: MA organizations using Option #2 of the streamlined marketing process, and Medicare Cost Plans, may submit marketing materials earlier than this date). • Due date to submit Provider Specific Plans and Renewal Plan Splits as outlined in Part III, Section 1 of these renewal instructions.
August 6	• The 2005 Model EOCs will be available to all plans – MA and Cost.
September 7-9	• Annual Enrollment and Payment Conference-Hyatt-Baltimore.
September 13	• Final day for MA organizations to submit CY 2005 ACRPs via HPMS. • Final day for MA organizations and cost plans to submit the 2005 Drug Discount Card Program enrollment fee via the 2005 ACRP. • Final day for MA organizations with employer-only plans to renew their CY 2005 ACRPs via HPMS. • MA organizations and Medicare cost plans should have already submitted CY 2005 SBs and ANOCs (including ANOCs for the Drug Discount Card Program) to Regional Offices so that these materials can be reviewed and approved prior to the October 19 posting of Medicare Personal Plan Finder. Note: MA organizations that have a Medicare-Approved Discount Card Program do not need

	to create a separate ANOC. • MA organizations and Medicare cost plans may begin marketing CY 2005 benefits to Medicare beneficiaries using CMS-approved marketing materials. MA organizations must submit ACRP to CMS prior to marketing these benefits and must use the "pending Federal approval" disclaimer until CMS approves the ACR. All organizations must cease marketing CY 2004 plans through public media when they begin marketing CY 2005 benefits. • MA organizations and Medicare cost plans are required to include information in CY 2004 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2005.
September 15	• Due date for MA plans to submit data for the computation of their MA-level working aged factor.
September 17	• Final date for MA organizations to send <u>non-model</u> ANOCs to CMS Regional Offices. MA organizations are encouraged to submit all ANOCs to CMS in advance of this date to ensure the ANOC can be reviewed, approved, printed, and received by members by the October 31 deadline. <u>Note:</u> if the MA organization follows the model ANOC without modification, the final date to send the ANOCs to the CMS Regional Office is <u>October 20</u>.
September 20-22	• MA organizations and Medicare cost plans preview the 2005 *Medicare & You* Handbook data in HPMS prior to CMS publication.
September 20-22	• MA organizations and if applicable, Medicare cost plans, preview the 2005 "Medicare Personal Plan Finder" (MPPF) plan data in HPMS prior to Internet release.
October 2	• Medicare cost plans (HMO/CMP) budget forecast are due no later than 90 days prior to the beginning of the contract period. This date is October 2 for calendar-year cost plans renewing on January 1.
October 12-30	• CMS mails *Medicare & You* for CY 2005, which will contain health plan benefit and cost information.
October 4	• Final date to review and approve the CY2005 ACRPs submitted by MA organizations offering one or more plans with a benefit reducing the Part B premium.
October 16	• Final date for Medicare cost plans to send <u>non-model</u> ANOCs to CMS Regional Offices. Cost plans are encouraged to submit all ANOCs to CMS in advance of this date to ensure the ANOC can be reviewed, approved, printed, and received by members by the December 1 deadline. <u>Note:</u> if the Medicare cost plan follows the model ANOC without modification, the final date to send the ANOCs to the CMS Regional Office is November 20.
October 19	• Date that MPPF data goes up on the web

October 30	• All organizations must cease marketing CY 2004 plans through public media.
October 31	• CY 2005 ANOCs (with SBs) (including ANOCs for the Drug Discount Card Program) are due to all MA members. MA organizations must mail the ANOCs and SBs before this date to ensure receipt by members by October 31
November 1	• Tentative date for CMS's approval of all CY 2005 renewal ACRPs. • MA organizations may begin submitting Mid-Year Benefit Enhancements and proposals for new mid-year plans. • Health Care Prepayment Plans (HCPPs) budget forecast are due no later than 60 days prior to the beginning of the contract period. For calendar year HCPPs this date is November 1.
November 15 – December 31	• Annual election period. MA organizations must hold open enrollment.
December 1	• CY 2005 ANOCs (with SBs) are due to all cost plan members. Medicare cost plans must mail the ANOCs and SBs before this date to ensure receipt by members by December 1.
December 17	• Final date for MA organizations and Medicare cost plans to send non-model EOCs to CMS Regional Offices. This also includes non-model Member Handbooks for the Drug Discount Card Program. organizations are encouraged to submit all EOCs to CMS in advance of this date to ensure the EOC can be reviewed, approved, printed, and mailed to members by the February 1, 2005 deadline. Note: if the organization follows the model EOC without modification, the final date to send the EOCs to the CMS Regional Office is January 23, 2005. This also includes the model language for Member Handbook for the Drug Discount Card Program. Note: Exclusive Card sponsors may combine the EOC and Model Member handbook.

2005	
January 1	• Effective date for CY 2005 plan benefits. • Last day to submit 2005 PFFS applications.
February 1	• Final date to mail CY 2005 EOCs to members. • Last day to submit new coordinated care plan application, including local PPOs.
March 1	• Last day for MA plans to submit a 2005 service area expansion request
April 21	• Compliance with the HIPAA Security regulation (for large plans)
April (1st Monday of month)	• Announcement of MA capitation rates, MA local area benchmarks and adjustment factors for CY2006

June 1	• Last effective date for new 2005 coordinated care plans and PFFS plans. • Last effective date for a 2005 service area expansion • Last submission date for mid-year enhancements
June 6th (1st Monday of month)	• Final day for MA and MA-PD organizations, regional PPOs, and Prescription Drug Plans to submit CY 2006 bids via HPMS. Medicare Cost plans offering qualified prescription drug coverage must also submit information by this date.

CALENDAR FOR THE 2005 MA NON-RENEWAL PROCESS

2004	
June 2004	• CMS posts final non-renewal instructions and beneficiary plan withdrawal Qs & As on the CMS websites.
August 1	• Deadline for MA organizations to notify CMS of an intention to non-renew a county for individuals, but continue the county for employer group health plan members. • CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS websites, and sends copies of the letters to MA organizations that are non-renewing or reducing their service area. • Deadline for MA organizations to submit partial county service area reduction requests.
September 13	• Deadline for MA organizations to submit a non-renewal or service area reduction notice to CMS.
September 15	• CMS issues an acknowledgement letter to all MA organizations that are non-renewing or reducing their service area.
September 20	• CMS approves MA organizations' final notification letter. • CMS will release a Special Election Period (SEP) letter to MA organizations remaining in the non-renewed service areas. • MA organizations can begin mailing the final notification letter. The final notification letter must be personalized and dated 10/2/04. The letter must be in the beneficiaries' hand by 10/02/04.
September 2004	• CMS will release detailed information on the 2004 non-renewals. • Press Release: Statement from CMS Administrator (Tentative)
October 2	• MA organizations must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.
November 17	• CMS issues " close out" information/instructions to MA organizations that are non-renewing or reducing their service area.

- Early Notification: If MA organizations notify the public of a nonrenewal before September 13, then it must send a CMS-approved interim notification letter to beneficiaries.

CALENDAR FOR THE 2004 MEDICARE COST PLAN NON-RENEWAL PROCESS

2004	
August 1	• CMS posts the 2004 Medicare cost plan non-renewal instructions on the CMS website. • CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS websites and sends copies of the letters to Medicare Cost Plans that are non-renewing or reducing their service area.
October 2	• Deadline for Medicare cost plans to submit a non-renewal or service area reduction notice to CMS.
October 9	• CMS issues an acknowledgement letter to all Medicare cost plans that are non-renewing or reducing their service area.
October 14	• CMS approves Medicare cost plans' final beneficiary letter and public notice.
October 23	• Medicare cost plans can begin mailing the final notification letter. The final notification letter must be personalized and be in the beneficiaries' hands by 11/03/04.
December 2	• Medicare cost plans must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.

PART I. STATUTORY AND REGULATORY INFORMATION FOR ALL RENEWING ORGANIZATIONS

Moratorium on Therapy Caps

Section 624 of the MMA reinstated the moratorium on therapy caps through the end of calendar year 2005. This means that through the end of calendar year 2005 fee-for-service Medicare will pay for unlimited medically-necessary physical, occupational and speech therapy services regardless of whether or not those services are provided in an outpatient hospital setting. Since there will be no financial limitation on payment for these services under the fee-for-service Medicare program, MA and Medicare Cost organizations will also be required to pay for these services for their members without imposing a financial cap or payment limit.

MA Open Election Period (OEP) Limitations ("Enrollment Lock-In") Delayed

The Medicare Modernization Act (MMA), section 102(a)(1)(A), amends the Social Security Act (the Act) at section 1851(e)(2) delaying the OEP limitations, or "enrollment lock-in," until 2006. In 2005, MA eligible individuals may make unlimited OEP enrollment and/or disenrollment elections. CMS will reflect the delay of OEP limitations through the Manual update process and in upcoming rulemaking.

Definition of MA PPO Plan Type

The PPO plan definition in section 1852(e)(2)(D) of the Act includes three elements. Under this definition (which is retained under MMA amendments effective in 2006, at 1852(e)(3)(A)(iv)), and MA PPO plan must:

(1) Have a network of contracted providers that have agreed to a specified payment rate for covered benefits;
(2) Provide for reimbursement for all covered benefits regardless of whether those benefits are provided within the network of providers; and
(3) Be offered by an MA organization that is not licensed or organized under State law as a health maintenance organization. (As discussed below, an organization that is licensed as an HMO may still become an MA PPO.)

Under the statute, this definition applies for purposes of determining what level of quality assurance requirements applies. Under our authority to ensure that marketing materials are not misleading, however, we are also applying the first two prongs of this definition to any plan that is offered as a "PPO," even if it is treated as a coordinated care plan for purposes of quality assurance rules. This is because we believe that from a beneficiary's perspective, they should know what to expect of a plan labeled as a "PPO" product, and there should not be varying meanings of the same plan type.

This means that a plan which is identified to beneficiaries as a MA PPO plan must provide reimbursement for **all** covered benefits - both in and out of network. An MA organization cannot "cap" or otherwise restrict payment for covered services under a PPO plan simply because those services were provided by or received from a non-contracting provider. Nor can an MA PPO plan limit or restrict out of network access for covered services. MA organizations are permitted to impose higher cost sharing on PPO plan enrollees for non-emergent out-of-

network services. However, annual, lifetime or other limits on payment for out-of-network services are not permitted to the extent that they do not also apply to in-network services of the same type and only to the extent they are consistent with original Medicare coverage limits and/or the plan's PBP.

Should a plan wish to offer a product that permits out of network access to covered services, but limits such access, it should be labeled a "point of service" product, not a PPO plan.

Because only the first two prongs of the statutory PPO definition apply to plans that are not seeking treatment as a PPO plan for quality assurance purposes, such plans may be offered by MA organizations that are licensed or organized under State law as a health maintenance organization. An MA organization licensed under State law as an HMO does not need to re-incorporate as a non-HMO entity under State law in order to offer a PPO plan to Medicare-eligible individuals under the MA program, as long as it meets the first two prongs of the above definition, and complies the quality assurance requirements in section 1852(e)(2)(A) that apply to all other MA coordinated care plans.

Extended Federal Preemption Authority in the MMA

The MMA amended section 1856(b)(3) of the Act relating to Federal preemption of State law. Section 1856(b)(3) now reads:

> "The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency)."

The reason for such a broad preemption authority is that Congress intended that, with the exception of licensing and solvency requirements, the MA program operate solely under Federal rules. This broadened preemption authority applies prospectively. That is, it is effective December 8, 2003, - the date the President signed the MMA into law.

The MMA also amended section 1854(g) of the Act, which prohibited States from imposing taxes on premiums paid to MA organizations by CMS. Section 232 of the MMA amended section 1854(g) to provide that States are also expressly prohibited from imposing a premium tax, or similar type of tax, on premiums paid by beneficiaries or third parties on behalf of beneficiaries enrolled in MA plans offered by MA organizations.

Pre-MMA Stabilization Fund Expiration

In the original DIMA (MMA) ACR "Resubmission" Instructions and accompanying Questions and Answers available on the CMS web site at http://www.cms.hhs.gov/healthplans/acr, we explained that the MMA restructures the way that MA organizations will be paid by CMS in calendar years after 2005. One affect of this new payment methodology will be expiration of the authority to retain money in pre-MMA stabilization fund accounts. We explained in the Instructions and accompanying Questions and Answers that MA organizations should make every effort to remove dollars from their pre-MMA stabilization fund accounts during contract years 2004 and 2005, since unused funds will revert to the Treasury on January 1, 2006.

Rehabilitation and LTC Hospitals Inclusion in 422.264 Rules

Section 211(e) of the MMA amended section 1853(g) of the Act, Section 1853(g) provides for special payment rules in situations in which a Medicare beneficiary's MA plan enrollment begins or ends while the beneficiary is a hospital inpatient. The MMA expands the list of hospital facilities covered under the special payment rules to add three new facility-types. They are: rehabilitation hospitals, distinct part rehabilitation units and long-term care hospitals. These three new types of facilities are added to subsection (d) hospitals (defined in section 1886(d)(1)(B)) for purposes of the special payment rules described in regulation at 42 CFR 422.264. Prior to passage of the MMA, only subsection (d) hospitals were reimbursed "fully" by either CMS (through payment by the fee-for-service intermediary) or the MA organization - based on the enrollment status of the Medicare beneficiary at the time of admission. Rehabilitation hospitals, distinct part rehabilitation units and long-term care hospitals are now to be reimbursed in the same way. That is, "full" payment is based on the enrollment status of the Medicare beneficiary at the time of admission. Note that this change in payment responsibility was effective on January 1, 2004.

PART II. ADMINISTRATIVE CHANGES AND UPDATES

Changes in Risk Adjustment Implementation

Specific changes in implementation that differ include updated risk adjustment data collection and submission dates:

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
2004	Jul 1, 2002– Jun 30, 2003	Sep 5, 2003	Jan 1, 2004	NA**
2004*	Jan 1, 2003-Dec 31, 2003	Mar 5, 2004	Jul 1, 2004	May 13, 2005
2005	Jul 1, 2003- Jun 30, 2004	Sep 3, 2004	Jan 1, 2005	NA**
2005*	Jan 1, 2004-Dec 31, 2004	Mar 4, 2005	Jul 1, 2005	May 15, 2006
2006	Jul 1, 2004- Jun 30, 2005	Sep 2, 2005	Jan 1, 2006	NA**
2006*	Jan 1, 2005- Dec 31, 2005	Mar 2, 2006	Jul 1, 2006	May 15, 2007

*Denotes non-lagged schedule.

**With the elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15th of each year. There is no September 30th deadline.

Changes in payment methodology for the CMS-HCC risk adjustment model are described in the March 26, 2004, 45 Day *Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates* (http://cms.hhs.gov/healthplans/rates). Changes include a new risk adjustment model and payment methodology for MA ESRD enrollees.

Risk Adjustment for ESRD Enrollees

A new risk adjustment model for enrollees who are currently paid under the ESRD payment system or who have functioning kidney transplants will be fully implemented in 2005. Because of the nature of the system there will be no phase-in blend of the new ESRD payment approach with the old. The new risk adjustment system has three payment modes: dialysis patient, transplant patient and functioning graft patient. The dialysis component has a state-based

ratebook reflecting costs for dialysis patients only. The coefficients for the dialysis risk model reflect the relative costs of demographic and disease groups in the dialysis population.

A beneficiary is switched to the transplant payment mode in the month of transplant. Payments for this group are made over three months, and reflect the costs of a transplant and the two months post hospital discharge. After the three transplant months, a beneficiary will move to the functioning graft payment mode. If dialysis is restarted at this time or later, a patient will move back to dialysis payment. The functioning graft payment mode uses a model almost identical to the general population model (i.e., the CMS-HCC model). There are, however, add-on factors for being in the first 9 months after transplant or in the period beyond. The earlier period factors reflect higher costs than the later. Because the law currently authorizes payments for immunosuppressive drugs indefinitely, the post graft period does not have a mandated stop date. Payment will still stop after 36 months for those beneficiaries who lose Medicare eligibility because ESRD is their sole eligibility reason.

Final implementation and approval are in the May 10, 2004 *Announcement of Calendar Year 2005 Medicare Advantage Payment Rates*. Complete instructions for risk adjustment implementation will be published in chapter 7 of the Medicare Managed Care Manual (http://cms.hhs.gov/manuals/116_mmc/mc86toc.asp). This information is cross referenced on: http://cms.hhs.gov/riskadj.

Drug Formulary Policy

CMS is providing MA organizations and Medicare cost plans the opportunity to change their drug formulary during the contract year. Plans are allowed to add or remove drugs from their formulary and move drugs to different tier levels. Plans that wish to remove a drug from their formulary during the contract year are required to establish an exceptions process. The exceptions process will provide physicians a mechanism to continue prescribing drugs that are determined to be medically necessary and which are otherwise consistent with the MA organization's pharmacy benefit management initiatives (such as adherence to clinical guidelines) and that were on the formulary at the beginning of the CY 2005 contract year or on the date on which the Medicare beneficiary enrolled, whichever is later. Organizations that change their formulary must provide a description in their Evidence of Coverage (EOC) stating that they might remove a drug from the formulary or move a drug to a different tier during the contract year. In addition, enrollment materials and the EOC must provide information on the availability of the exception process. The Medicare Advantage organization or Cost HMO/CMP will determine how the exceptions process will work and can include reviewers who determine whether or not the request for an exception is medically appropriate and/or whether or not an exception will be granted.

Not usually self-administered drugs administered incident to physician services

Effective August 1, 2002 if an MA enrollee wishes to receive a "not usually self-administered" drug in a physician's office, the MA organization must cover the drug and the service of administering the drug. That is, MA organizations may not make a determination of whether it was reasonable and necessary for the patient to choose to have his or her drug administered incident to physician services. (MA organizations can continue to make determinations

concerning the appropriateness of a drug to treat a patient's condition, and the appropriateness of the intravenous or injection form as opposed to the oral form of the drug.)

MA organizations can choose to cover, as an additional benefit, injectable drugs that the local carrier has determined are not usually self-administered but that members purchase at a pharmacy and administer at home. However, MA enrollees always have the option of receiving the Medicare-covered benefit, i.e. administration of the covered drug in a physician's office.

This requirement does not apply to, or affect, Medicare cost plans and their cost reports.

Discontinuance of Fee-for-Service Payment for Three National Coverage Determinations (NCDs)

In 2003, CMS issued three separate NCDs that met the significant cost threshold described in section 1852(a)(5) of the Social Security Act and 42 CFR 422.109 of the Medicare regulations. These NCDs were:

1. Expanded coverage of implantable automatic defibrillators, effective October 1, 2003.
2. Ventricular assist devices used for destination therapy, effective October 1, 2003.
3. Lung volume reduction surgery, effective January 1, 2004.

As stated in 42 CFR 422.109(b), if CMS determines and announces that an NCD meets the significant cost criteria an MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service. Therefore, as stated in our memoranda to plans on these NCDs, CMS will make payments on a fee-for-service basis for services directly related to these NCDs from the effective date of each of these NCDs through December 31, 2004.

In accordance with 42 CFR 422.109(d), MA organizations are not liable for payment for costs relating directly to the provision of these NCD services until January 1, 2005, when payments can be appropriately adjusted to take into account the costs of these NCD services. As of January 2005, these services or benefits are included in the MA organizations' contracts and are covered benefits under the contract. MA organizations must furnish, arrange, or pay for these NCD services and MA plan enrollees are liable for the plan's cost sharing for these services.

Reporting of ESRD Status

To implement the new ESRD risk adjustment method, CMS will utilize the existing ESRD information system as the standard for identification of enrollees receiving dialysis services and transplants. However, MA organizations will be given the opportunity to notify CMS directly of a transplant in order to receive more timely transplant payments. CMS will send a technical systems letter in late summer to inform MA organizations of the procedures for direct notification of a transplant. Ultimately, any ESRD status reported by an MA organization will be reconciled against CMS's existing ESRD information system to determine final ESRD status for payment.

Health Insurance Portability and Accountability Act (HIPAA)

The Administrative Simplification provisions of HIPAA require that the Secretary of the Health and Human Services adopt a set of national electronic data interchange (EDI) standards for the health care industry. The Department was to adopt standards for: (1) transactions and code sets, (2) identifiers for health plans, providers, employers, and individuals for use in the transactions, (3) security of health information, and (4) privacy of health information.

MA organizations, Medicare cost plans, and HCPPs are designated as health plans and must comply with the HIPAA requirements. All health plans must have the capability to exchange covered transactions electronically and meet the other HIPAA requirements as a covered entity. CMS will continue to provide specific instructions for transactions and code sets, privacy, and security in separate letters.

Medicare Managed Care System (MMCS)

MMCS replaces the legacy Group Health Plan (GHP) system later this year. This includes an online replacement for MCCOY. Overall, the impacts will be minimal; the transaction and report formats will not be changing. There will, however, be additional transaction reply codes and a replacement of the Plan Transfer Tracking Report. A brief explanation is included in this letter. CMS will be providing specific information on the transition to the new MMCS in July. This communication will provide details on the new transaction reply codes and testing that will be available to all organizations.

The new transaction reply codes are listed below.

REPLY CODE	DESCRIPTION
150	Enrollment accepted; but the capacity limit has been exceeded.
151	Disenrollment accepted, but the disenrollment reason code was invalid. FUTURE USE
152	The beneficiary's race code has changed.
153	The beneficiary's temporary address has changed.
154	The beneficiary's address has changed and is no longer in the service area.
155	Beneficiary has become incarcerated.
156	Batch transaction rejected; submitted by user unauthorized for the MA Organization.
157	Transaction rejected as MA Organization was not authorized to submit that transaction type.
158	CMS staff revised or cancelled an institutional period for a member.
159	CMS staff revised or cancelled an NHC period for a member.
160	Batch transaction rejected; submitted by user unauthorized to submit batch transactions.

The Plan Transfer Tracking Report is used by all organizations to determine if their transmissions made it to CMS and were picked up for processing. Under MMCS, this functionality will be replaced by the Rejected Transaction File and the Failed Transaction File. The rejected file contains transactions that failed system edits. The failed file contains transactions that could not be edited. Both of these files can be downloaded. Organizations will also have the ability to view accepted and rejected transactions using the online system interface. This online view will allow you to correct the rejected transactions.

There is a MMCS Tutorial available at https:/cms.hhs.gov/healthplans/systems that can provide hands-on experience.

Medicare+Choice to Medicare Advantage

As part of the new Medicare Advantage program, all Medicare+Choice organizations and plans become Medicare Advantage organizations and plans. This means that an organization has the option to begin the transition from "M+C" to "MA" now, but must complete the transition no later than the Fall of 2005 in preparation for Contract Year 2006. Information on how to manage this transition in marketing materials was addressed in a March 16, 2004 memorandum entitled "Medicare Advantage: Guidance on Marketing Materials and Plan Names," which can be found at http://www.cms.hhs.gov/healthplans/marketing/default.asp.

Reconciliation of ZIP Codes

MA organizations and Medicare cost plans that have an approved service area with partial counties will need to regularly reconcile the zip codes within the approved partial counties. The post office is continually adding new zip codes, and reassigning or splitting others. CMS regularly updates zip codes in its database for full counties, but the Central Office (CO) plan managers do maintenance of partial counties manually.

Although it has always been an expectation that MA organizations and Medicare cost plans would review their service areas, many have not done so. The need for this reconciliation has become increasingly important within the last few years, as CMS has moved to data driven decisions and systems. The accuracy of information in the Medicare Personal Plan Finder (MPPF) about MA plan(s) and Medicare cost plans is only as good as the data about their partial counties in CMS' system. Additionally, a number of MA organizations in recent years have requested reduction of partial county service areas during the non-renewal season. In this case, CMS needs accurate zip code information about the current partial counties in order to analyze the demographic impact of proposed reductions, which is part of the decision making process.

MA organizations and Medicare cost plans should contact their CO plan manager for instructions about the specific information they must submit to document the need for service area zip code revisions. (Please note that this revision process may not be used to add new areas to a current service area.) When submitting revisions to the appropriate CO plan manager, MA organizations and Medicare cost plans should also send an informational copy to their Regional Office (RO) plan manager.

Special Needs Plans

Interim Guidance Regarding MA Special Needs Plans for Dual Eligible and Institutionalized Individuals

Section 231 of the MMA allows MA organizations to offer plans that serve special needs individuals. The legislation designates two specific segments of the Medicare population as special needs individuals. These are institutionalized individuals (as defined by the Secretary) and those entitled to Medical Assistance under a State Plan under Title XIX. Through regulations the Secretary may designate other chronically ill or disabled beneficiaries as "special needs beneficiaries" to allow plans to enroll additional high-risk groups who would benefit from a specialized MA plan.

The following questions and answers are designed to provide interim guidance for organizations that wish to offer MA Special Needs Plans (SNPs) to Medicare beneficiaries who are also entitled to Medicaid and/or those who are institutionalized. MA organizations with an existing MA plan that serves these beneficiaries may apply to CMS to have the plan "redesignated" as an MA SNP. An organization that does not currently have an MA contract and wishes to offer an MA SNP must apply for an MA contract and meet the requirements of an MA plan. An MA SNP may serve either dual eligible or institutionalized beneficiaries, or both. Further information about the submission process is provided below.

At this time, MA organizations may not submit applications for new Special Needs Plans (or for resdesignation of existing plans) to serve other chronically ill or disabled beneficiaries. CMS will provide guidance about these types of plans through rulemaking. CMS also intends to provide guidance for those MA organizations that also have contracts with State Medicaid agencies and offer a combined package of Medicare and Medicaid benefits to their members. These organizations may wish to offer an MA SNP that serves their dual eligible members and be able to coordinate the benefits of the two programs. Because of the various issues surrounding the coordination of these benefits, and also the issue of which rules apply to these benefits, CMS intends to solicit comments through rulemaking and will provide guidance in the future. CMS is committed to working with State agencies and health plans to facilitate more flexibility in coordinating Medicare and Medicaid benefits.

Finally, CMS intends to solicit comments on this provision of the MMA through rulemaking. Therefore, this interim guidance is subject to change in the future.

Q1: *Can MA organizations begin offering MA Special Needs Plans immediately?*

A1: MA organizations may immediately begin submitting proposals to CMS for new Special Needs Plans to exclusively enroll: (1) Institutionalized Medicare beneficiaries; (2) Dual eligible Medicare beneficiaries. That is, beneficiaries entitled to Medical Assistance under a State Plan under Title XIX, (Medicaid).

CMS will make every effort to review proposals as quickly as possible. Once approved, MA SNPs may begin operating at any time during the year.

Q2. *Can current MA plans be "redesignated" as an MA Special Needs Plan?*

A2. Yes, an existing MA plan that has dual eligible or institutionalized enrollment may request redesignation as a special needs plan. Generally, CMS will look at such proposals to determine that it meets access standards for the proposed special needs group and that the plan is of value for special needs beneficiaries. If approved, the plan can market itself as an MA Special Needs Plan. Once "redesignated" the plan must provide appropriate notice and must exclusively enroll the targeted special needs group. Question and Answer 10 address the status of existing members of MA plans that are "redesignated."

Q3: *How does CMS define "institutionalized" for purposes of MA Special Needs Plans?*

A3: For purposes of this interim guidance, CMS defines an institutionalized individual as a MA-eligible who resides or is expected to reside continuously for 90 days or longer in a long-term care facility that is either a skilled nursing facility (SNF), nursing facility (NF), or SNF/NF. These individuals are considered long-term institutional residents for purposes of determining who can enroll in a special needs plan.

Q4: *Can an MA organization establish a Special Needs Plan that serves a "subset" of the dual eligible or institutionalized population?*

A4: Pending rulemaking, MA Special Needs Plans must serve all dual eligibles, including those entitled to Medicare Part A and Part B and full Medicaid benefits, Qualified Medicare Beneficiaries, Special Low-income Medicare Beneficiaries, QI-1s, etc. We believe requiring MA SNPs to serve all dual eligibles is consistent with CMS payment methodology since CMS pays organizations equally for all dual eligible beneficiaries regardless of whether they are "full benefit dual eligibles" with incomes below the federal poverty level or those with higher incomes. Also, from a policy perspective, we believe that the Conference agreement accompanying the MMA legislation indicates that the basic intent of special needs plans is to provide organizations the flexibility to identify groups of beneficiaries with special health care needs that will benefit from specialized services. Accordingly, we don't believe segmenting the dual eligible population based on relative income status (i.e., full benefit versus higher income duals) is consistent with this Congressional intent. However, we note that, based on industry comments and experience, we may modify this policy in the upcoming regulations.

In addition, for the third category of MA SNPs (those targeted to select groups of high-risk beneficiaries who would benefit from enrollment in plans that offer targeted geriatric approaches and innovations in chronic illness care), which will be implemented by rulemaking, we may consider SNPs that target selected segments of the dual eligible population based on their particular health care needs.

With respect to institutionalized beneficiaries, CMS recognizes that a SNP might not contract with every SNF or NF within its service area. Therefore, a SNP may serve those beneficiaries in one or more institutions in the service area, subject to CMS' review and approval. In this

situation, the plan must be marketed to all Medicare beneficiaries within those institutions that are part of the SNP's network.

Q5: *In the case of dual eligibles, can those individuals not yet confirmed to be entitled to Medicaid be enrolled in an MA Special Needs Plan prior to verification?*

A5: No. The individual must meet all eligibility requirements, including entitlement to Medicaid, before enrolling in an MA Special Needs Plan. In other words, the individual must have Medicaid, as evidenced by a Medicaid card, letter, systems verification, including a CMS reply listing, etc. Any one of the aforementioned documents or systems verifications is acceptable proof of Medicaid entitlement. Meanwhile, the beneficiary may wish to join another of the MA organization's plans and then, once entitlement to Medicaid is confirmed, change to the MA SNP by completing an appropriate election (e.g., an enrollment or selection form). Model enrollment and selection forms are shown in the Exhibits section of Chapter 2 of the *Medicare Managed Care Manual*. If the MA plan prefers to use abbreviated forms, such as Exhibits 3 or 3a of Chapter 2, the forms may be modified to elicit information that the beneficiary is eligible to enroll in an MA SNP. Modified forms will be subject to marketing material review. (Also, see Q&A 9.)

Q6: *Will those who wish to enroll in an MA Special Needs Plan be given a Special Election Period to do so?*

A6: Beneficiaries may make an unlimited number of elections during the Open Enrollment Period (OEP), which is continuous through 2005 (see *Medicare Managed Care Manual (MMCM)*, Chapter 2, Section 30.3.1). Dual eligibles have a Special Election Period (SEP) from the time they become dually eligible and continuing as long as they remain dually eligible (MMCM, Chapter 2, Section 30.4.4). During the Open Enrollment Period for Institutionalized Individuals (OEPI), which is continuous beginning in 2006 (MMCM, Chapter 2, Section 30.3.5), beneficiaries going into, residing in, or leaving an institution can join any open MA plan. CMS is considering the need for a SEP for those who are no longer eligible for a SNP to enable them to enroll in a non-Special Needs Plan.

Q7: *What is the application process for an MA Special Needs Plan?*

A7: Any current MA organization interested in offering or being redesignated as a Special Needs Plan must submit its request to CMS Central Office with a copy to the appropriate CMS Regional Office. The Central Office Plan Manager and the Regional Office Plan Manager will review the submitted material and make a determination based on the information submitted as part of this proposal. The Central Office Plan Manager will inform the organization of the decision.

When submitting a formal request, the organization must submit as part of its proposal, 1) a description of the proposed plan; 2) an explanation of how the contracted provider network(s) will meet access and availability standards; 3) an explanation of what types of providers will participate (e.g., Home Health), 4) a description of the benefits, clinical programs, etc. and; 4) the proposed effective date for the new plan.

For MA organizations that do not have a current contract with CMS, the full MA application must be completed in order to offer a special needs plan. The application is posted at: http://www.cms.hhs.gov/healthplans/applications/m+caps.asp. (Note: we are in the process of modifying the application to conform with the new MMA requirements, but in the meantime, the old application may be used. This application has not been adapted for MA SNPs.) New applicants using this application should also include the information requested in the second paragraph above as a supplement to the application. We anticipate that, once finalized, a new application that includes MA SNP information will be posted on our website.

***Q8**: Will an MA Special Needs Plan be paid differently from other MA plans?*

A8: No, MA Special Needs Plans will be paid the same as other MA plans. The MMA does not give CMS the authority to waive MA payment methodologies. There are no special payment features specific to MA SNPs. However, risk adjustment is being phased in for MA plans. Under risk adjustment, payments are more accurate because they reflect the health status of an organization's enrollees. See 2005 Medicare Advantage Payment Rates at http://www.cms.hhs.gov/healthplans/rates for further details. In addition, CMS is currently conducting research to determine the feasibility of implementing the frailty adjuster for the MA program. If we determine that this is appropriate, the earliest that frailty adjustment would be applied to MA plans would be 2006.

***Q9:** Once a plan is redesignated as an MA Special Needs Plan, can members of other plans within the MA Organization be passively enrolled in the new plan?*

A9: No. Members of the MA Organization's other plans who meet the eligibility requirements must complete a new enrollment election, such as an enrollment or selection form, to join the MA Special Needs Plan (see Q&A 5).

***Q10:** Can MA organizations limit enrollment in new MA Special Needs Plans and plans that are "redesignated" as MA Special Needs Plans to individuals who meet specified eligibility requirements (i.e., are dually eligible or institutionalized)?*

A10: Yes. Pending rulemaking, MA organizations offering new and redesignated SNPs must limit future enrollment to individuals who meet specified eligibility requirements (see Q&A 4). However, existing members who do not meet these requirements must be allowed to remain in the redesignated plan. These members will be granted a Special Election Period (SEP) beginning when the plan is redesignated and continuing through the end of the calendar or contract year, or ninety (90) days if redesignation occurs less than ninety days before the end of the calendar or contract year. The SEP will enable the member to enroll in another MA plan (including one within the same MA Organization) or change to Original Medicare. A "redesignated" MA Special Needs Plan cannot involuntarily disenroll an existing member who does not meet the special needs eligibility requirements at the end of her/his SEP. However, once an existing member has disenrolled from the SNP, s/he may not rejoin.

Q11: *What happens if an MA Special Needs Plan member's status changes so that s/he no longer meets the eligibility requirements?*

A11: An MA Special Needs Plan may continue to provide care for a specified period for a member who no longer has special needs status as long as the plan can provide appropriate care. For example, a dual eligible who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if, in the absence of continued coverage, the member would be expected to meet the eligibility requirements within the timeframe established by the plan, which must be at least 30 days. If the member does not re-qualify within this time period, s/he must be involuntarily disenrolled with proper notice, from the plan at the end of this period.

If the SNP cannot provide continuity of care to a member who loses eligibility, such as to an institutionalized individual, then the plan must involuntarily disenroll the member. The plan must inform all beneficiaries in writing of its continuous eligibility policy at enrollment, apply it consistently and provide the beneficiary with a minimum of 30 days notice after the plan determines the member is no longer eligible. This notice must provide the member an opportunity to prove that s/he is still eligible to be in the plan. Upon involuntary disenrollment, CMS will grant the beneficiary a Special Election Period (SEP) in order that s/he may enroll in another MA plan or obtain coverage to supplement Original Medicare.

In the case of a retroactive Medicaid disenrollment, an MA SNP may not retroactively disenroll the beneficiary. The plan may disenroll the member only after providing a minimum of 30 days' notice.

Q12: *Will ESRD beneficiaries be allowed to enroll in MA Special Needs Plans?*

A12: CMS will consider requests from MA Special Needs Plans to waive restrictions on enrollment of ESRD beneficiaries. However, MA SNPs will not be required to enroll ESRD beneficiaries. Members of MA SNPs who develop ESRD while a member of that plan may remain a member of that plan as long as they continue to meet all other eligibility requirements.

Q13: *What kind of marketing/outreach will CMS permit for MA Special Needs Plans?*

A13: MA Special Needs Plans must follow the marketing guidelines in Chapter 3 of the Medicare Managed Care Manual. Since some Chapter 3 requirements may not be applicable to a particular SNP, CMS will work with SNPs on a case-by-case basis until Chapter 3 is updated to accommodate all SNP marketing requirements. MA SNP for dual eligibles may follow the supplemental CMS guidance; "Marketing to Individuals Entitled to Medicare and Medicaid (Dual Eligibles)" issued October 7, 2003.

A "redesignated" plan may submit to its CMS Regional Office for review new plan marketing materials tailored specifically for the "special needs" population, but must not begin using those approved marketing materials until it receives a letter from CMS that approves its "redesignation." The plan cannot begin exclusively enrolling those who fit the special needs eligibility requirements until it receives the approval letter from CMS.

A new plan may begin using CMS-approved marketing materials tailored specifically for the "special needs" population and accepting only prospective enrollees who fit the special needs eligibility requirements after CMS has approved the new plan and its ACR and PBP.

Q14: *Will MA Special Need Plans need to meet any additional requirements beginning in 2006?*

A14: Yes. MA Special Needs Plans should be prepared to offer Part D Prescription Drug coverage. Effective January 2006, CMS anticipates that only MA-PD plans will be allowed to continue or apply for a Medicare contract as a SNP. An MA SNP offering Part D Prescription Drug coverage could not also be the MA organization's required MA-PD plan for that service area because enrollment is limited.

Q15: *How will an MA Special Needs Plan identify special needs beneficiaries in order to do marketing and outreach?*

A15: Dual Eligible MA Special Needs Plans may wish to work with their respective states to identify an acceptable method of targeting dual eligible beneficiaries. In the case of all MA SNPs, as with any MA organizations, the MA SNP must market to all individuals eligible for the plan. This means, for example, that if an MA SNP is developed for institutionalized beneficiaries at select SNFs, the MA SNP must market to all Medicare A/B beneficiaries residing in those SNFs.

Q16: *Will administrative variances be available to MA Special Needs Plans?*

A16: MA Special Needs Plans are expected to follow existing Medicare program rules, including Medicare Advantage policy and regulations, as modified by this guidance with regard to Medicare-covered services. This includes MA SNPs that serve dual eligibles. MA organizations should assume that if no modification is contained in these guidelines, existing rules apply.

Q17: *Can MA Special Needs Plans take Medical Assistance applications for prospective members or assist current members with eligibility redeterminations, have the member sign them and then deliver them to the State Medicaid agency?*

A17: MA Special Needs Plans will need to obtain State Medicaid agencies' permission to do so and make logistical arrangements through the State(s). The Medicare Managed Care Manual discusses outreach to dual eligibles in Chapter 3, Section 40.4.

Q18: *If an MA Special Needs Plan has a premium/copayment, can it waive it for members who have full Medicaid coverage?*

A18: MA Special Needs Plans must apply the same premium/copay requirements to all members. However, the State may wish to pay the premium/copays for certain members.

***Q19**: Would CMS do a direct mailing to FFS members in an MA Special Needs Plan's service area if the plan provides approved marketing materials and pays postage and mail service?*

A19: No, CMS cannot perform this service.

***Q20**: Could an MA Special Needs Plan enroll a prospect if he/she signs an attestation of Medicaid eligibility and disenroll the member if the State determines them to not be eligible?*

A20: No.

***Q21:** How can an MA Special Needs Plan verify that an applicant is entitled to Medical Assistance?*

A21: Medical Assistance recipients may have a Medicaid card or a letter from the state agency that confirms entitlement to Medical Assistance. Either of these documents are acceptable proof, even if systems documentation is not available. MA organizations have access to certain CMS systems information (via the Medicaid indicator in the Managed Care Option Information System, known as McCoy) for current plan members. Redesignated MA SNPs may confirm Medicaid entitlement from that information. If this systems confirmation is available, no other documentation is required. New MA SNPs must obtain other proof, such as that mentioned above, during the enrollment process.

PART III. RENEWAL PROCESS FOR 2005

Section 1. MA Plan Renewals

Background

An MA plan is the health benefits and pricing package that an MA organization offers to beneficiaries who reside in the plan's approved service area. MA organization can offer multiple MA plans in the same or different service areas. Each MA plan consists of basic benefits (Medicare covered benefits (Parts A and B) plus additional benefits) and any mandatory and/or optional supplemental benefits. As described in the MA regulations at 42 CFR 422.66, a beneficiary enrolls in a specific MA plan offered by an MA organization.

In general, CMS has determined that an MA plan that has a Plan Identification Number in contract year (CY) 2004 is a renewal MA plan in CY2005 if all or part of the MA plan's current service area remains in CY2005. MA organizations may change the benefits of a renewal MA plan from year to year. MA organizations may also add new MA plans, reduce the service area of a renewal MA plan, expand the service area of a renewal MA plan or terminate an MA plan. Within the established definitions and guidelines discussed below, CMS will determine how beneficiary rights will be ensured and how beneficiary elections will be made.

Definitions

Existing MA Plan: An approved MA plan in which the service area is fixed for the term of the contract (CY2004 Plan ID Number).

Contract Service Area: The service area approved for an MA organization by CMS, within which an MA eligible individual or employer-group member may enroll in a particular MA plan(s).

Plan Service Area: The defined service area, within which an MA plan must be available to all MA eligible individuals or employer-group members who reside in the area.

MA Plan Renewal: An existing CY 2004 MA plan that will continue to operate (in CY2005) in all or part of the MA Plan's service area.

MA Plan Termination: An existing MA plan offered in CY2004 in which Medicare beneficiaries are currently enrolled, but the MA plan will not be offered in CY2005.

MA Plan Service Area Expansion (SAE): The addition of an approved full county or an approved partial county to an existing MA plan during the ACR Renewal Process.

MA Plan Service Area Reduction (SAR): The removal of an approved full county or an approved partial county from an existing MA plan during the ACR Renewal Process.

Passive Elections

Under Medicare laws and regulations, Medicare beneficiaries must make an election to enroll in an MA plan and CMS specifies the form and manner in which such elections are made. CMS has determined that it is legally permissible to provide for enrollment in an MA plan under a passive election process in specific, limited circumstances as shown in the chart that follows. A passive election is defined as a process by which a beneficiary is informed that he or she may make an election of a new MA plan by taking no action.

When a passive election is used in connection with a service area reduction (SAR) or plan termination, the MA organization must send a modified ANOC to the enrollees setting forth the available options, including Medigap rights. Although the ANOC information ordinarily may not be due until a later date, the MA organization must provide the ANOC information for the new MA Plan by October 2, 2004. This will satisfy the MA plan termination notification requirements and give the enrollees time to decide whether to "elect" the new plan by taking no action.

When a passive election is used in an MA plan renewal that ***does not*** include a termination or SAR, there are no Medigap rights. The MA organization should use the regular ANOC and include passive enrollment language to inform enrollees about their respective plans and other choices for CY2005.

MA Plan Renewal Guidelines and Operational Instructions for MA Organizations

The following chart outlines the MA plan renewal guidelines and describes the relationships that can be established between CY 2004 and 2005 plans and how each one relates to the HPMS plan crosswalk, the enrollment system actions to be performed by either the MA organization or CMS, whether and which type of enrollment application is required, and the requirements for beneficiary notifications. **It is extremely important that MA organizations review this chart**

for guidance when determining their plan structures for CY 2005. Technical instructions for completing the HPMS plan crosswalk for each type of relationship will be provided to MA organizations separately.

Contract Year 2005 Guidance for Medicare Advantage Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
1	New Plan Added		A new 2005 plan with no link to a 2004 plan.	The MA organization must submit election transactions.	Beneficiaries are required to complete an enrollment form. Beneficiaries who are already enrolled in another plan in the same organization can complete the short enrollment form.	Beneficiaries are sent a regular ANOC.
2	Renewal Plan	If an MA organization continues to offer a CY2004 MA plan in CY2005 and retains all of the same service area, **it must retain the same Plan ID number** in order for all currently enrolled beneficiaries to remain in the same MA plan in CY2005.	A 2005 plan that links to a 2004 plan and retains all of its plan service area from 2004.	**The renewal plan ID must remain the same** so that beneficiaries will remain in the same plan ID. The MA organization **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
3	Consolidated Renewal Plan	If an MA organization ***combines*** two or more MA Plans offered in CY2004 into a single renewal plan so that all beneficiaries in the combined plans are offered the same benefits in CY2005, the MA organization must designate which of the renewal Plan IDs will be retained in CY2005 after consolidation. **Note:** If an MA organization reduces a county while performing this activity, the MA organization must follow the Renewal Plan with SAR rules for handling beneficiaries in the reduced county.	Two or more 2004 plans that consolidate into one 2005 plan.	**The MA Organizations designated renewal plan ID must remain the same** so that CMS can consolidate the beneficiary's election by moving them in the designated renewal plan ID. The MA organization **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
4	Renewal Plan with an SAE		A 2005 plan that links to a 2004 plan and retains all of its plan service area from 2004, but also adds one or more new counties.	**The renewal plan ID must remain the same** so that beneficiaries in the current service area will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. However, the MA organization must submit election transactions for the beneficiaries involved in the service area expansion.	Beneficiaries who wish to enroll for the new county are required to complete an enrollment form. An exception is that only the short enrollment form needs to be completed if the beneficiary is currently enrolled in another MA plan offered by the same MA organization.	Beneficiaries are sent a regular ANOC.

Contract Year 2005 Guidance for Medicare Advantage Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
5	Renewal Plan with a SAR.	If an MA organization ***reduces the service area*** of a CY2005 MA Plan and makes the reduced area part of a new or renewal MA Plan service area in CY2005, the MA organization must offer passive elections in CY2005 to all of the current enrollees who reside in the reduced service area. ***Note:** When the SAR county(ies) is not contained in another MA plan (contract SAR), the MA organization must submit transactions to disenroll the beneficiaries from the plan. Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights. To enroll in a different MA plan, these beneficiaries must complete an enrollment form. The model modified ANOC will be available on the CMS website at: http://www.cms.hhs.gov/healthplans/ by August 6, 2004.	A 2005 plan that links to a 2004 plan and retains only a portion of its plan service area.	**The renewal plan ID must remain the same** so that beneficiaries in the renewal portion of the service area will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. When the SAR county(ies) is contained in another plan, the MA organization **must submit transactions** to passively enroll the beneficiaries into another plan.	Beneficiaries in the renewal portion need do nothing. Beneficiaries impacted by the plan SAR **must be offered passive elections into another plan offered by the organization.**	Beneficiaries continuing in the same plan that were not impacted by the SAR are sent a regular ANOC. Beneficiaries impacted by the plan SAR (passively enrolled) are sent a modified ANOC and receive guaranteed issue Medigap rights.
6	Renewal Plan Split Based on Provider Groups	If one CY2004 MA Plan splits into two or more CY2005 MA Plans in order to reflect the beneficiary's provider group choice, both CY2005 MA Plans must have the same service area. The CY2004 MA plan ID must be designated as the renewal plan in CY2005. **Provider-Specific Plan Splits require prior approval from CMS.** MA Organizations wishing to offer provider-specific plans effective January 1, 2005 must submit their formal requests to their CMS Regional Office Plan Managers with a cc to their CO Plan Manager no later than August 2, 2004. CMS will review such requests on a case-by-case basis and make its determination based upon information that the MA organization submits as part of its proposal. For further information and format requirements, refer to the CMS website at: http://www.cms.hhs.gov/healthplans/.	Two or more 2005 plans that are created from one 2004 plan with membership determined by provider choice.	If the beneficiary's appropriate plan based on provider group choice is the renewal plan ID, beneficiaries remain in the same plan ID. The MA organization **does not** submit any transactions for these members. Otherwise, the MA organization **must submit transactions** to passively enroll beneficiaries into the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.

Contract Year 2005 Guidance for Medicare Advantage Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
7	Renewal Plan Split by Optional Supplemental Benefit Choice	If one CY2004 MA plan splits into two or more CY2005 MA Plans because one or more MA plans has a mandatory benefit based on last year's optional supplemental benefit, and therefore a different monthly premium, the CY2005 MA Plans must have the same service area and basic benefit cost-sharing amounts. The CY2004 MA plan ID must be designated as the renewal plan in CY2005. **Requires prior approval from CMS.** MA Organizations wishing to offer the Renewal Plan Split by Optional Supplemental Benefit Choice effective January 1, 2005 must submit their written requests to Randy Brauer with a cc to their CMS Central Office and Regional Office Plan Managers no later than August 2, 2004.	A CY2004 plan that has an optional supplemental benefit(s) is split into 2 or more plans; 1 with only basic benefits and 1 (or more) with the same basic benefits and the former optional supplemental(s) as a mandatory benefit(s).	If the beneficiary's appropriate plan based on benefit choice is the renewal plan ID, beneficiaries will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. Otherwise, the MA organization **must submit transactions** to passively enroll beneficiaries to the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.
8	Renewal Plan Split by Premium and/or Cost-sharing based on segmented service area	The MA organization splits an existing CY2004 MA Plan service area in CY2005 and the only difference between the MA Plans is premium charge and/or cost-sharing. A segment cannot be smaller than a payment area (e.g. county). The MA organization must submit a separate ACRP for each segment. The CY2004 MA plan ID must be designated as the renewal plan in CY2005.	A 2004 plan that is segmented into two or more 2005 Plan IDs that share identical benefit packages with the exception of premium and/or cost-sharing.	If the beneficiary's appropriate plan based on service area is the renewal plan ID, beneficiaries will remain enrolled in the same plan ID. The MA organization **does not** submit any transactions for these members. Otherwise, the MA organization **must submit transactions** to reflect the beneficiary's election based on service area.	Nothing is required	Beneficiaries are sent a regular ANOC.
9	Terminated Plan		A 2004 plan that is no longer offered in 2005.	If the beneficiary elects to enroll in another plan with the same organization, the MA organization **must submit transactions** to enroll the beneficiary in another plan with the organization; CMS disenrolls beneficiaries to FFS who do not elect another plan with the same MA organization or a different MA organization.	Beneficiaries are required to complete an enrollment election if they choose to enroll in another plan. Beneficiaries who elect to enroll in another plan with the same organization can complete the short enrollment form.	Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights.

* Note: See the non-renewal instructions for a contract non-renewal or service area reduction.

HPMS Plan Crosswalk and the Medicare-Approved Drug Discount Card

As with past years, MA organizations will be required to complete the HPMS plan crosswalk when uploading their Contract Year 2005 ACRPs. MA organizations that are serving as exclusive drug card sponsors must consider their drug card offerings when designing their plan structures for 2005.

In Contract Year 2004, CMS provided approval to exclusive sponsors to offer their Medicare drug discount cards to members enrolled in certain plan benefit packages. For some exclusive sponsors, the combined service area for those plan benefit packages equaled the entire contract service area; for others, it represented only a portion of the contract service area.

When designing plan benefit package structures for 2005, exclusive sponsors must continue to offer a Medicare-approved drug discount card in the **same** set of counties as were covered by the drug card in 2004. These counties may be covered by the same set of plan benefit packages as in the prior year, new or different plan benefit packages, or a combination of these packages.

During completion of the 2005 plan crosswalk, HPMS will apply validation rules to require that exclusive sponsors offer their Medicare-approved drug discount card in at least one plan benefit package in each county covered by a drug card in Contract Year 2004.

Section 2. Guidance for ACR/PBP submissions

ACR Worksheet Changes

The method used by MA organizations to calculate ACRs for 2005 generally will be the same as for 2004. However, The ACR pricing forms will have the following changes for CY 2005. For example:

- Worksheet A (Cover Sheet).
    - For contract year 2005 ACRPs, the actuarial value of the fee-for-service Medicare deductible and coinsurance amount for all counties is $119.36 PMPM for Part A/B enrollees and $89.12 PMPM for Part B-only enrollees. These amounts will be pre-loaded into the worksheet.
    - A section for ACR filings of MA MSAs has been added to the worksheet. Section 223(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) had the affect of making the MSA program a permanent part of the MA program. The MMA also removed the previous cap on MSA enrollment.
    - The worksheet will allow withdrawals from but not additions to a stabilization fund. **NOTE:** Under MMA, all monies in stabilization funds on January 1, 2006 will be forfeited to the Medicare Trust Funds.
- Worksheet A1 (Service Area and Estimate of Annual Payment Rate)

- The worksheet will allow for the statutory change in the phase-in of risk adjustment of payment rates for 2005. The payment rates for 2005 will reflect 50 percent demographic factors and 50 percent risk adjustment.
- Reformulate the worksheet's calculation for the enrollees in county 99999 to reduce the chances of errors by users.
- The worksheet no longer has Part IV, which was for entering January and February 2004 catch-up payments the MMA authorized for certain contract year 2004 ACRP filings.

The items outlined above do not represent an all-inclusive list. The ACR instructions for 2005 will summarize all of the changes to ACR forms and instructions. Also, the instructions will be modified to conform to the changes listed above.

Grouping of Health Care Components

As in prior years, MA organizations will be permitted to group data in the health care components (lines 1-19) on Worksheet B of the ACR. However, grouping methods used in prior years will not necessarily be acceptable in 2005, especially methods that group all cost data on one line. CMS is requiring MA organizations to use as many health care components as possible. Payments made on a capitation basis should be allocated to the appropriate health care component. Reasonable allocation methods, including using claims data as a basis for the allocation, is acceptable. CMS realizes that these allocations are estimates.

At a minimum, CMS would like to see data allocated to the following lines (if applicable):

Line 1 –Inpatient Hospital Services
Line 2 – Skilled Nursing Services
Line 4 – ER/Post Stab./Urgent Care
Line 6 – Home Health
Line 7 – Health Care Professionals
Line 8 – Clin./Diag./Therap.Rad. Lab
Line 9 – Outpatient Hospital Services
Line 10 – Ambulance/Transportation
Line 11 – DME
Line 12 – Renal Dialysis
Line 15 – Outpatient Drugs/Prescription Drug
Line 19 – POS
Line 20 – COB

Prior approval of the grouping methodology is not required. However, MA organizations must include a detailed description of the grouping method in the substantiation submitted with the hard copy of the ACR. See the "Transmittal Instructions" for more information.

Also, MA organizations will be permitted to group data in the health care components on Worksheet D using the same grouping methodology that is used on Worksheet B. As with Worksheet B, MA organizations must include a detailed description of the grouping method in the substantiation submitted with the hard copy of the ACR.

Changes to the Plan Benefit Package (PBP) and Summary of Benefits (SB)

CMS continues to work with MA and cost plans to improve both the PBP and the SB. For CY 2005, several enhancements have been made to the PBP and the SB. Some of these changes are detailed below. A list of all CY 2005 changes can be found on HPMS in the ACRP Submissions module.

PBP Changes

PBP Notes

A second optional Notes field has been added to each major section (A, B, C, and D) of the PBP software for organizations to provide further detail regarding the plan's benefits that cannot be fully explained in the regular data entry sections of the software.

PBP Section B

In category 15-Outpatient Prescription Drugs, the software now allows the user to specify one or more groups for which the maximum plan benefit coverage amount is waived. Additionally, users now have the ability to define a periodicity for the enrollee's maximum out-of-pocket drug cost if the pre-defined list if inexact.

PFFS plans will now have the option to specify if an additional copayment exists when prior authorization is not established for a planned inpatient hospital, inpatient psychiatric, and/or SNF admission. If it does, then the user is required to specify an enrollee out-of-pocket limit. PFFS plans will also have this option for any equipment or device purchases made prior to receiving authorization.

Section C

The software now provides the ability to further define the connection, if one exists, between the OON and in-network maximum plan benefit coverage amount as well as the connection between the OON and in-network maximum enrollee out-of-pocket cost.

Note for PPO Demonstrations that imposes penalties for failure to obtain prior authorization: In Section C, on OON-General Base 3, after the plan says "yes" to "If there is a violation of the Authorization requirements, is there a penalty?" and subsequently selects the service categories to which the penalty applies, the plan **must** specify in the Notes section how much the penalty is for each type of service that has a penalty.

SB Changes

SB Section 1

Customer service hours have been added preceding the current and prospective member general phone numbers.

SB Section 2
OON sentences are now available for all plan types offering OON benefits.

The following service categories contain revised sentences: Inpatient hospital care, inpatient mental health, skilled nursing facility, outpatient services/surgery, durable medical equipment, prosthetic devices, diagnostic test, x-rays, and lab services, immunizations, and outpatient prescription drugs.

In addition, revisions and additions have been made to SB sentences in hopes of providing more clarity related to describing:

- Deductibles for in-network and out-of-network services
- Maximum out-of-pocket limits
- Maximum benefit coverage (in-network & out-of-network) for benefits

Drug Card ACRP Instructions
CMS will allow MA organizations to include, in the ACR, administrative costs related to any discount card enrollment. Enter such costs (on a per-member, per-month basis - PMPM) on line 25ev2 of the Medicare-covered benefits column of Worksheet D. The costs should reflect your estimate of the number of enrollees that will elect the discount card as an optional supplemental benefit. In order for the PMPM value on line 25ev2 to be consistent with other ACR values, please compute it using the total projected plan membership. The entry on line 25ev2 cannot exceed $2.50 PMPM.

CMS has not incorporated questions regarding the exclusive Medicare discount drug cards into the PBP software. However, as with last year, MA organizations that will offer exclusive Medicare discount cards to enrollees of an MA plan will be required to answer specific questions about the card when they upload their 2005 ACRPs to HPMS.

Instructions for Submitting Employer Group Health Plans
MA organizations are permitted to develop MA plans offered exclusively to Medicare beneficiaries who are members of an employer or union group. This type of plan allows the MA organization to develop a minimal base package that can be customized for specific employers or unions. In developing an employer-only plan, CMS encourages MA organizations to create a benefit package with as few mandatory supplemental benefits as possible. This gives MA organizations flexibility in negotiating with employers and/or unions. The portion of the final benefit package that results from negotiations with employers and/or unions are not required to be submitted to CMS.

MA organizations that wish to renew employer-only plans offered in contract year 2004 are required to electronically submit both an ACR and PBP for the renewal employer-only plans via HPMS. These renewal employer -only plans must be submitted by September 13, 2004 for a January 1, 2005 effective date. The same versions of the ACR and PBP software will be used for these plans as for other MA plans. MA organizations renewing employer-only plans for CY 2005 will see their plan structures pre-populated in HPMS based on CY 2004 data.

New employer-only ACRPs may be submitted at any time during the calendar year. CMS recommends submitting new employer-only plans 3-4 weeks prior to the requested effective date. However, all submissions received for CY 2005 will only be effective through December 31, 2005.

Both new and renewal employer-only plans submitted by the September 13, 2004 deadline will automatically be given a January 1, 2005 effective date. New employer-only plans created and submitted after the September 13, 2004 deadline, but no later than December 1, 2004 for a January 1, 2005 effective date, must enter January **2**, 2005 as the proposed effective date in HPMS. This ensures that approval of your renewal ACRPs is not delayed by the submission of a new employer-only plan during this time period. Upon approval of the new ACRP, CMS will change the effective date to January 1, 2005.

A Medicare beneficiary with Medicare coverage only under Part B cannot elect an MA plan after December 31, 1998, unless they are members of employer or union groups. If MA organizations plan on enrolling Medicare beneficiaries with Part B-only coverage in an employer-only plan, these organizations must prepare a Part-B only ACRP. Failure to create a separate B-only plan will result in the rejection of any enrollments submitted on behalf of individuals without Part A by the CMS managed care payment system. Please note that this separate Part B only ACRP is for enrollees of employer or union groups only and is distinct from Part B only plans that are used for grandfathered individual members. Further guidance on developing B-only plans is provided in the "Instructions for Completing the ACRP Form for Contract Year 2005."

MA organizations can offer a service area to their employer group health plans that is larger than is offered to their MA plans for Medicare individuals. **MA organizations that intend to offer a larger service area must notify their CMS CO plan manager no later than 30 days in advance of uploading their employer-only plan ACRP to HPMS.** CMS must have advance notification to ensure that the new employer group health plan counties will be included in HPMS for the plan creation process. In addition, submit documentation of state licensure in the extended counties to your CMS CO plan manager.

CMS will continue to exclude Employer-only plans from the Medicare Personal Plan Finder (MPPF) and the Handbook.

EGHP Enrollment Reporting by Medicare Advantage Organizations

Beginning in 2005, CMS will begin to track the enrollment of EGHP members. CMS can identify the EGHP members that are enrolled in EGHP-only plans. However, not all EGHP members are enrolled in those plans. For this reason, CMS will require MA Organization reporting. The method for submittal and the data required will be developed in a way to minimize burden on the MA Organizations.

Further information regarding this activity will be forthcoming in late summer 2004.

Mid-Year Benefit Enhancements (MYBE)

CMS will continue to permit MA and Cost-based organizations to enhance their benefit plans during 2005. Pursuant to 42 CFR 422.300(b)(1), enhancements may include one or a combination of the following elements:

- Adding new benefits at no additional cost to the plan enrollee;
- Reducing premiums;
- Reducing cost-sharing (i.e., copayments, coinsurance, and deductibles); or
- Adding new benefits with some premium and/or cost-sharing. This type of MYBE may be offered as follows:
  - Adding new mandatory supplemental benefits with cost-sharing (not permitted for Cost-based organizations);
  - Adding new optional supplemental benefits with premium and/or cost-sharing.

A mandatory supplemental benefit may be added to a MA plan for $0 premium. All beneficiary costs for new mandatory supplemental benefits must be in the form of cost-sharing. In this way the beneficiary retains the right to either access the new benefit (with financial liability for the additional cost-sharing) or not. MA and Medicare Cost plans are permitted to offer optional supplemental benefits with an additional monthly premium (with or without additional cost-sharing), but only with explicit CMS approval. Again, the beneficiary retains the right to either access the new benefit (with financial liability for the additional premium and/or cost-sharing) or not.

A revised ACR & PBP submitted through HPMS is required for MA plans. In addition, a hardcopy of the ACR, including new signatures, and any supporting documentation related to the enhancement must be mailed to the following address:

LMI
Attn: ACRP
2000 Corporate Ridge
McLean, VA 22102-7805

CMS will begin accepting proposals to enhance benefit plans beginning November 1, 2004 and continuing through June 1, 2005. Proposed enhancements will be effective no earlier than February 1, 2005 and must obtain prior approval from CMS. Organizations may request that an enhancement be effective at some later date, however, all effective dates must occur on the first of the month.

Organizations are required to notify plan members of benefit enhancements at least 30 days prior to the effective date. All member notifications and other revised marketing materials must be submitted to the CMS regional office for approval. The streamlined marketing process will continue to apply to benefit enhancements (see Section 20.3 of Chapter 3 of the Medicare Managed Care Manual). Therefore, approved marketing materials that include the disclaimer, “pending federal approval”, may be sent to plan

members prior to the approval of the ACRP. However, the ACRP must be successfully submitted electronically through HPMS before any marketing materials related to the enhancement may be sent. It is recommended that organizations submit proposals for benefit enhancements at least 45 days prior to the requested effective date to meet the 30-day member notification requirement.

New Mid-Year Plans

MA organizations may submit an ACRP to create new MA plans through April 2005. The new MA plan must be introduced in an approved service area, meet network adequacy requirements, and have reasonable benefits and cost sharing. New plans must be approved by CMS and may not be marketed prior to CMS approval of the plan. The new plan cannot replace any existing plans where the ACR has been approved. The MA must maintain an adequate provider network to ensure access and availability of all medical services for existing plans and the new mid-year plan. The approved renewal plans must continue to be marketed to members throughout the contract year even if a new plan is offered in the same service area during the contract year. An ACR & PBP submitted through HPMS is required. In addition, a hardcopy of the ACR, including signatures, and all supporting documentation for the new plan must be mailed to the following address:

LMI
Attn: ACRP
2000 Corporate Ridge
McLean, VA 22102-7805

CMS will begin accepting ACRPs to add a new MA plan in 2005 beginning November 2004 and continuing through April 2005. Upon upload of the ACRP for the new plan in HPMS, the MA organization will be asked to select a proposed effective date. New plans will be effective no earlier than February 1 and no later than June 1 during the contract year. Please note that all effective dates must occur on the first of the month. The approved effective date may differ from the proposed effective date depending on the review and approval process of the application. The new mid-year plan application can be found at http://www.cms.hhs.gov/healthplans/applications/

Cost-sharing Guidance

In the last two years CMS included cost-sharing guidance in the annual call letter to assist MA organizations in the preparation of the adjusted community rate proposals (ACRPs). This guidance had been developed in response to the high cost-sharing features of many ACRPs that had been submitted in previous years. Of particular concern prior to 2003 were the substantial increases in beneficiary cost-sharing that were experienced for dialysis and chemotherapy drugs. These services are still of particular concern. In addition, for the 2003 benefit year CMS noted further substantial cost-sharing increases in other medical categories such as inpatient stays; outpatient facilities; and ambulatory surgical centers. For the 2005 benefit year CMS will continue to focus on high cost sharing for Medicare-covered benefits in reviewing ACRPs. We will not approve any ACRP that we find would have the effect of discriminating based on health status. We

plan to pay greater attention to plans that have high co-insurance percentages in addition to those with high copayments. We will apply similar scrutiny to cost-based plans and in reviewing any Part B premium reduction plans (BIPA 606). CMS will not approve any BIPA 606 plan whose cost-sharing appears to substantially negate the Part B premium refund.

The following two regulatory citations provide general guidance to MA plans on benefit design and cost-sharing limits.

- 42 CFR 422.308 establishes a global actuarial equivalency standard for basic benefits which permit coordinated care plans to allocate premiums and cost-sharing, as long as those allocations do not exceed, in the aggregate, an annually published national actuarial per member per month limit. In contract year 2005 this amount will be $119.36
- Medicare Advantage regulatory requirements specify that organizations may not design benefit packages that discriminate, discourage enrollment or hasten disenrollment of severely ill or chronically ill beneficiaries - 42 CFR 422.100(g) and 42 CFR 422.752(a)(4).

CMS will use the following factors in reviewing proposed 2005 MA organizations cost-sharing amounts:

1. Plans that set a total annual cost-sharing cap on member liability at an appropriate level will have great latitude in establishing cost-sharing amounts for individual services. CMS will review caps to verify that they are within actuarial standards. Working with the
   CMS Office of Actuary, we have determined that a total annual cap of $2,710 for out-of-pocket expenses for Medicare-covered services, excluding monthly basic premium would be an appropriate level for this purpose. We reached this conclusion by considering the method of setting out of pocket caps in the Federally-qualified HMO program, enrollee costs under Medigap, and continuance tables of out-of-pocket costs for Medicare services.

   With acceptable justification, we will also give some latitude to those plans with out-of-pocket (OOP) caps above $2,710 that impose higher copay amounts as long as the cost sharing is spread across widely used health care services. We will not approve plans with higher caps that concentrate cost-sharing on specific services, such as dialysis and chemotherapy drugs.

2. CMS will carefully examine plans that do not have an annual cap on member liability that meets the level identified above. This is to ensure that the proposed cost-sharing structure does not discriminate against “sicker” beneficiaries, or that the proposed cost-sharing structure does not inappropriately encourage disenrollment or discourage enrollment. We are particularly concerned with the cost-sharing levels for dialysis and chemotherapy drugs.

3. CMS will use fee-for-service (FFS) cost sharing for a given service as a reference point when evaluating proposed MA cost-sharing amounts for a specific service.

We recognize that some FFS services have no cost-sharing, such as home health, and will accept reasonable cost-sharing levels for these services. However, to ensure against discriminatory practices, CMS will review all cost-sharing to ensure that out-of-pocket costs on specific items and services, e.g. Medicare covered drugs, are not significantly higher than cost-sharing imposed on services in general.

4. 4.We also will pay attention to high cost-sharing levels that are charged for each admission to an inpatient setting or skilled nursing facility. We encourage MA organizations to consider cost-sharing levels to be based on benefit periods as administered under Original Medicare. In Original Medicare, a benefit period begins the day a Medicare beneficiary enters the hospital, or skilled nursing facility, and ends when the member has received no additional hospital or SNF services for a period of 60 days in a row. A Medicare beneficiary is charged the hospital or SNF deductible only once during this benefit period regardless of the number of admissions. CMS will allow some latitude for organizations that incorporate benefit periods into their benefit designs.

5. No dollar limits can be placed on the provision of Medicare-covered drugs. CMS does, however, encourage health plans to include the cost of these drugs in any cap that limits beneficiary out-of-pocket costs.

In reviewing ACRPs, CMS will consider that premiums and broad-based deductibles are more equitable ways to spread costs than copays and coinsurance, since these premiums and deductibles spread costs more broadly among enrollees. We plan to provide feedback to plans as soon as possible after the ACRPs are submitted on any concerns with regard to their proposed cost-sharing amounts. This is estimated to begin about September 20th.

Health Plan Management System (HPMS)

Reminder Concerning HPMS Access Change

On Friday, April 2, 2004, CMS migrated HPMS to a new physical location within the Medicare Data Communications Network (MDCN). As a result, MA and cost organizations have three alternatives for accessing HPMS:

- Internet access via a Secure Socket Layer Virtual Private Network (SSL VPN) using your corporate Internet Service Provider (ISP);
- T-1 lease line access via AT&T Global Network Services (AGNS); or
- Dial-up access via AGNS.

Internet users will access HPMS at https://gateway.cms.hhs.gov, whereas AGNS users will use http://32.91.239.68. All three methods require the use of a Microsoft Internet Explorer web browser version 5.1 or higher and a CMS-issued user ID and password with access to HPMS. If your organization requires assistance with establishing

connectivity to HPMS in its new location, please contact Don Freeburger at either 410-786-4586 or DFreeburger@cms.hhs.gov.

HPMS User IDs and Passwords

MA and where applicable Cost organizations must use HPMS to electronically submit their ACRs and PBPs for Contract Year 2005. CMS requires that all users obtain a CMS-issued user ID and password to access the system. Please contact Neetu Jhagwani at either 410-786-2548 or NJhagwani@cms.hhs.gov to obtain a user ID and password for HPMS access.

HPMS System Updates

CMS has implemented the following HPMS changes for the Contract Year 2005 renewal season:

- Exclusive Drug Card Sponsor Information – CMS has implemented several new fields in the General Information Module to support the ongoing operations of the Medicare-approved drug card program. A subset of these fields is being used to display information about exclusive drug card sponsors in both Medicare Personal Plan Finder (MPPF) and the Prescription Drug Assistance Program (PDAP) websites on www.medicare.gov. HPMS will ask MA and cost organizations to provide the following information: the website address for the exclusive drug card program, whether this website lists drug prices, whether the exclusive drug card sponsor is using a third-party vendor to assist with transmissions to the Enrollment Eligibility and Verification System (EEVS), and the primary and secondary contacts for the reconsideration process.

- Customer Service Hours – HPMS will ask MA and cost organizations to provide their customer service hours. This information will be used to populate both the Summary of Benefits (SB) and the MPPF website.

Section 3: Marketing

Retrospective Review of Marketing Materials

Section 20.3 of Chapter 3 of the Medicare Managed Care Manual describes the streamlined review for marketing materials. As part of that review, CMS conducts and annual retrospective review of the Annual Notice of Change (ANOC) and Summary of Benefits (SB). For plan year 2004, the retrospective review results were not as good as last year, which means that more organizations were required to mail corrected materials to members. Most errors found during the reviews were fairly common and can easily be avoided to prevent having to send a costly addendum to all members for plan year 2005. The most common errors were:

- Inserting the incorrect copayment or coinsurance for a particular service on the ANOC and/or SB. In these cases, careful review of the submitted PBP in comparison to the marketing materials can easily prevent these errors.

- Providing information on the ANOC and/or SB that is not supported in the ACR and/or PBP. In most cases, an organization can prevent these errors by carefully ensuring that the PBP (and ACR) is filled out accurately for all plan benefits and by taking advantage of the Notes section of the PBP to more fully describe benefits.

We encourage you to carefully and thoroughly review your materials prior to sending them out. If you ever have a question about your materials, call your RO for advice before sending them out.

Marketing CY 2004 and 2005 Benefits

Marketing of CY 2004 Plans. All MA organizations and Medicare cost plans must cease using public media to market CY 2004 plans beginning October 30, 2004. If the organization begins marketing its CY 2005 plans any time between September 13 and October 30, it must cease using public media to market the CY 2004 plans on the day it begins marketing the CY 2005 plans. "Public media" includes billboards, radio, TV, print advertisements and direct mail.

Renewing plans may continue to send and orally present CY 2004 plan information to individuals who specifically ask for it and to employer group members, and may continue to enroll individuals for effective dates before January 2005, based on an individual's election period and on other requirements of the law, regulations, and previously issued guidance. If a prospective enrollee inquires about the 2004 plan, the organization should provide the individual with both 2004 and 2005 plan information so that the individual is fully informed about changes that will take place on January 1.

In general, MA organizations and Medicare cost plans must submit all remaining CY 2004 marketing materials to CMS by no later than July 25. This deadline will allow CMS to begin focusing resources on the review of CY 2005 marketing materials. In some unique circumstances an organization may need to have CY 2004 marketing materials reviewed after July 25. In those cases, the organization should contact its Regional Office to arrange for review of these materials.

Effective September 13, all MA organizations and Medicare cost plans must include disclaimers in CY 2004 marketing materials whenever they advertise a CY 2004 benefit, premium, or copayment that may or will change effective January 1, 2005, or whenever it accepts an election form for an effective date in 2004 after September 1. (The disclaimer is not required if the organization knows that benefits will not change in 2005). The disclaimer must be in the form of an attachment or an addendum to all marketing materials, including advertisements and election forms, and must alert potential members that changes will occur on January 1.

The following model disclaimer may be used by organizations with benefit changes in 2005. Additional RO review and approval is not required if this disclaimer is used verbatim, but is required if it is modified.

> [Insert any or all of the following, whichever is appropriate: Benefits, premiums and/or copayments][insert whichever is appropriate: "may" or "will"] change on January 1, 2005. Please contact [insert organization name] for details.

Marketing of CY 2005 Plans. Beginning September 13, all MA organizations and Medicare cost plans may begin using approved CY 2005 marketing materials. MA organizations must submit an ACRP to CMS prior to marketing CY 2005 plans. All organizations must begin using approved CY 2005 marketing materials no later than October 31.

All marketing presentations and all mailings to Medicare beneficiaries concerning CY 2005 enrollment (annual election period) must include a Summary of Benefits (SB) describing CY 2005 benefit package information.

CY 2005 Annual Notice of Change (ANOC)

The ANOC highlights the specific changes in Medicare and plan benefits, plan premiums and plan rules effective January 1, 2005. A model ANOC for MA organizations and Medicare cost plans is contained in Section 40.1.3 of Chapter 3 of the Medicare Managed Care Manual. The SB must be included with the mailing of the ANOC.

All MA organizations and demonstrations must ensure that members receive the ANOC (with the SB) by October 31, 2004. All Medicare cost plans must ensure that members receive the ANOC (with the SB) by December 1, 2004. Because there are changes to Medicare coverage effective January 1, 2005 (see below), all members, including employer group members, must receive an ANOC and SB by these dates.

Please refer to the "Calendar for 2005 MA and Medicare Cost Plan Renewal Process" for the time frames for sending SBs into the Regional Offices for review. The time frames were established to ensure that organizations submit ANOCs and SBs in time to have them reviewed, approved, printed, and received by members by the October 31 (for MA organizations) and December 1 (for Medicare cost plans) deadlines.

The following changes to Medicare coverage go into effect on January 1, 2005, and must be mentioned in the ANOC. All of the changes are as a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). For your reference, we have included the section of the MMA that enacted these Medicare coverage changes.

MMA Section	Medicare Coverage Effective January 1, 2005
512	Hospice consultation services are covered (one time only) for a terminally ill individual who has not yet elected the hospice benefit.
611	*For members whose Medicare Part B coverage begins on or after January 1, 2005, and who have not already taken advantage of this benefit in another plan or Original Medicare:* A one-time physical exam within 6 months of your first coverage under Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.
612 *	Coverage of screening blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), including tests for cholesterol and other lipid or triglyceride levels.
613 *	Coverage of diabetes screening tests for persons at risk of diabetes, including a fasting plasma glucose test.

*** Note: CMS has been given the authority to establish the frequency that Original Medicare will cover these tests (for MMA section 612 the frequency is not to exceed once very two years and for MMA section 613 the frequency is not more than twice within the 12-month period following the date of the individual's most recent diabetes screening test). The agency expects to have defined these frequencies in final regulations by November 2004. If you intend to only cover these tests at the same frequency as Original Medicare, then for the ANOC we recommend that you tell members to call you if they need more information about how often they will be able to get these tests. The detail about Original Medicare frequencies should be available for you to publish in your EOCs.**

CY 2005 Summary of Benefits

All MA organizations and demonstrations must send a standardized SB to individual members with the ANOC. MA organizations and demonstrations must also send a SB to employer group members with the ANOC; however, they are not required to use the standardized SB for these members.

All Medicare cost plans must send a SB to all members with the ANOC. They are not required to use the standardized SB. However, if a Medicare cost plan intends to have its plan appear in Medicare Personal Plan Finder, it must complete the Plan Benefit Package (PBP) and create a standardized SB.

General instructions for the SB are included in Section 40.5 of Chapter 3 of the Medicare Managed Care Manual. All organizations will receive information regarding the 2005 SB changes by the end of June. Please remember that Section 3 of the SB is intended to describe special features of the plan beyond information contained in Sections 1 and 2 of the SB, to further describe mandatory and optional supplemental benefits that appear in the Section 2, and to describe non-Medicare endorsed drug discount programs (if appropriate and at the option of the organization). Section 3 is not intended to include a

description of every plan benefit not included in Section 2 that has cost sharing associated with it.

Please refer to the "Calendar for 2005 MA and Medicare Cost Plan Renewal Process" for the time frames for sending SBs into the Regional Offices for review. The time frames were established to ensure that organizations submit ANOCs and SBs in time to have them reviewed, approved, printed, and received by members by the October 31 (for MA organizations) and December 1 (for Medicare cost plans) deadlines.

Under unique circumstances, an organization may need to make a hard copy change to its standardized SB. Chapter 3, Section 40.5.3 of the Managed Care Manual outlines the process for requesting such changes

Questions about the SB and requests for hard copy changes should be sent to SummaryofBenefits.@cms.hhs.gov.

CY 2005 Evidence of Coverage (EOC)

All MA organizations and Medicare cost plans must mail CY 2005 EOCs to all plan members no later than February 1, 2005. After these organizations have mailed the CY 2005 EOC to all members, they must mail CY 2005 EOCs to new members no later than when they notify the member of acceptance (confirmation) of enrollment (the time frame requirements for sending notice of acceptance of enrollment are contained in Chapter 2, Section 40.4.2). NOTE: Chapter 3 states that the EOC must be mailed to new members no later than two weeks after the effective date of their coverage. In July, Chapter 3 will be updated to reflect the new time frame outlined in this Call Letter.

The HMO, PPO, and Medicare cost plan model EOCs will be available by August 6. Use of the model language is not mandatory; however, it will facilitate the review of the marketing materials.

Please refer to the "Calendar for 2005 MA and Medicare Cost Plan Renewal Process" for the time frames for sending EOCs into the Regional Offices for review. The time frames were established to ensure that organizations submit EOCs in time to have them reviewed, approved, printed, and mailed to members by the February 1, 2005 deadline.

"Medicare Personal Plan Finder" Data

Starting October 19, the CY 2005 health plan data will appear on the "Medicare Personal Plan Finder" in the standardized summary of benefits format. In addition, "Medicare Personal Plan Finder" will continue to include graphs displaying several HEDIS and CAHPS measures, as well as disenrollment reasons data.

Plans can preview their data in HPMS from September 20-22. If there are any issues with the data, plans can notify CMS at compchart@cms.hhs.gov.

National Year-to-Year Comparisons on the Website

Like this past year, CMS will be reporting differences in costs and benefits offered by health plans from 2004 and 2005 on its consumer website, www.medicare.gov.

CMS will provide a side-by-side comparison chart that summarizes the changes for key service categories so that users can quickly see information that may help them in making their health care decisions.

***Medicare & You* 2005**

It is expected that the health plan benefit and cost comparison information in *Medicare* & *You* 2005 will be similar to the health plan information provided in the Medicare & You 2004 booklet released last Fall. One CAHPS measure will be included in *Medicare* & *You* 2005.

Special Requirements for Medicare Cost Plans

CMS will again display comparative information about Medicare cost plans for CY 2005. To be included in CMS' information, Medicare cost plan contractors must submit a PBP via HPMS by September 13, 2004 for each benefit package they will offer in CY 2005. Benefit information about Medicare cost plan contractors who do not submit a PBP will not be included in *Medicare* & *You,* or in the "Medicare Personal Plan Finder." Medicare cost plan contractors will have an opportunity to preview their benefits data in HPMS on September 20, 2004 through September 22, 2004.

Medicare cost plan contractors who cannot submit a 2005 premium amount for their benefit packages in their PBP should send an email to the Center for Beneficiary Choices at compchart@cms.hhs.gov. In this circumstance, Medicare cost plan contractors should enter their CY 2004 premium amount in the PBP. Furthermore, Medicare & You will indicate "Not available" in the premium field and information in "Medicare Personal Plan Finder" will remain blank.

PART IV. MEDICARE ADVANTAGE ORGANIZATION NON-RENEWAL PROCESS FOR 2005

Section 1 –Notices and Letters

Interim Notification Letter - For MA Organizations giving official notification prior to September 13, 2004.

CMS may require an MA organization to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. MA organizations that use the 2004 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these MA organizations must inform their RO of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

MA organizations that revise the CMS Model Interim Notification Letter must submit their letter to their RO for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than October 2, 2004. CMS strongly encourages MA organizations to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated October 2, 2004 to assure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that MA organizations must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states are California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. Should there be changes to this list of states with additional protections, CMS will inform all non-renewing MA organizations prior to the time they develop their final notification letter.

MA organizations may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Finally, in accordance with 42 CFR 422.506(a)(2)(ii), CMS will provide each non-renewing MEDICARE ADVANTAGE ORGANIZATION with a list of those Medicare health plans (MA and Medicare Cost Plans), if any, that will be available to affected beneficiaries as alternative choices in 2005. Medicare Advantage Organizations must include this list of "remaining health plans" in final notification letters, including those health plans that have CMS-approved capacity limits. The letter must call special attention to the fact that Medicare Cost Plans may have a different open enrollment cycle from MA organizations. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas, of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

Regional Office Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS Regional Offices (ROs) prior to release. MA Organizations may submit draft copies of their final notification letters to CMS ROs as early as August 1, but no later than September 13, 2004. Since the final notification letter is reviewed as part of a separate and unique process, it is not subject to the 10-day rule for marketing material review, but the RO will give priority review to the submitted final notification letter. CMS strongly suggests that MA organizations use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. All RO reviews of final notification letters based on the model will be completed before September 13, 2004. CMS encourages MA Organizations to consider this review period when making plans to meet the October 2, 2004 deadline for delivery of these final notification letters to beneficiaries.

Medigap Information

Non-renewing MA organizations must inform all affected Medicare beneficiaries, including the disabled and individuals with End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Full information on this topic is provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter with appropriate language. If used, this model language will assure accurate communication of these technical provisions.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing MA organization in order to choose from a broader range of Medigap policies available on a

guaranteed issue basis. MA organizations must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2004 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to purchase certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp.

Public Notice of Non-Renewal

Non-renewing MA organizations must publish a public notice of non-renewal at least 90 days prior to the end of the contract year (i.e., October 2, 2003) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. MA organizations that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these MA Organizations must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

MA organizations that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages MA organizations to consider this review period when making plans to meet the October 2, 2004 deadline for release of these public notices.

Section 2 –Enrollment

Mandatory Enrollments: Initial Coverage Election Period (ICEP) and Special Election Period (SEP)

Non-renewing MA organizations **must** continue to accept enrollments from individuals during their ICEP and SEPs until November 30, 2004. MA organizations should address specific questions about enrollment closures to their RO Plan Managers.

Marketing/Enrollment Materials

Once the MA organization notifies CMS if its non-renewal decision, all marketing and enrollment materials to individuals in their ICEP or SEP must announce the MA Organization's decision to non-renew. The following is an example of the model language an MA organization may use in marketing and enrollment materials for individuals during an ICEP or SEP:

> ", <Insert plan name> will [(not be renewing its Medicare Advantage contract) or (will not be serving the following counties: <insert county names>)] effective January 1, 2005. You may choose to enroll in our plan, but your coverage will automatically end on December 31, 2004, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another MA

plan effective January 1, 2005, you will be changed to Original Medicare on that date. You will receive additional information about your rights and options for 2005 in a Final Notification Letter on October 2, 2004, or thereafter if your enrollment is after this date."

***NOTE*: A statement announcing the MA Organization's decision to non-renew must be included on all pre-enrollment and advertising-related materials. Sales representatives must use this language in all presentations about the plan. If the MA organization chooses to use the model addendum above, and simply to affix this to materials that have been approved by CMS, the material does not require CMS review or approval. However, if the MA organization modifies the addendum or marketing material in any way, the material (including the addendum) must be reviewed and approved by CMS prior to dissemination.**

Since MA organizations are required to accept ICEP and SEP enrollments through November 30, there may be a few cases where individuals are enrolled after an MA organization's final notification letters are mailed. In these cases, the MA organization must provide a final notification letter dated October 2, 2004 to each affected beneficiary, along with the confirmation of enrollment letter. These final notification letters must also include the individual beneficiary's name and address.

Section 3 - Systems Issues

Non-renewed Contracts

Non-renewing MA organizations should **not** submit disenrollments for any members who will remain in their organization through December 31, 2004. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the MA organizations has submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan are placed in Original Medicare in a timely manner.

Non-renewing MA organizations should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the MA organizations receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2004), Medicare Advantage organizations must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December 31,2004). Therefore, it is important that non-renewing MA organizations submit any final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

MA organizations will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

Service Area Reductions

MA organizations with service area reductions for 2005 must disenroll all members who reside in the non-renewed area or county**.** MA organizations must submit disenrollment records for all affected members no later than the cut-off date (12/9/2004) in December, the last operating month of their current contracts.

CMS will provide MA organizations with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third week of December 2004, and verify the disenrollments for all submitted members. MA organizations will also receive a separate communication with specific systems instructions from CMS.

MA organizations with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

Health Plan Management System (HPMS) Issues

Non-renewing MA organizations **must not assign** a Plan Benefit Package (PBP) in HPMS to any county that is included in the request for a service area reduction.

MA organizations that intend to non-renew a county for individuals, but to continue the county for employer group health plan members, must notify CMS of their intention in writing by August 1, 2004, in order for the HPMS system to accommodate the request. This notice should be sent to Rosanna Johnson at rjohnson3@cms.hhs.gov

Section 4 - Other Information

Partial County Service Area Reduction Requests

Service Area Reduction

The current county integrity policy affords CMS significant discretion to approve exceptions to the principle of county integrity. The general exceptions to the county integrity policy and documentation requirements can be found on pages 2 and 3 of OPL99.090 on CMS' website at http://www.cms.hhs.gov/healthplans/opl/opl090.pdf.

MA organizations must submit partial county requests to CMS for review and approval. CMS reviews each request on a case-by-case basis. In keeping with the current MA regulatory requirements, CMS will perform analysis of demographic information to ensure nondiscriminatory impact on excluded parts of a county or counties and excluded populations.

MA organizations should send requests to the appropriate Regional Office Plan Manager with a copy to Sid Lindenberg in CMS' Central Office. The request must be received at CMS no later than August 1, 2004.

"Close-Out" Information

In the Fall of 2004, CMS will send a "close-out" letter to non-renewing MA organizations with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to assure that affected beneficiaries experience a smooth transition from membership in the non-renewing MA organizations to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the MA organizations after the last day of its contract.

Non-renewing MA organizations may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract. If an affected Medicare member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing MA organization is responsible for all Part A inpatient hospital services until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B. If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing MA organization will pay the covered charges through the last day of the contract; Original Medicare or the next Medicare health plan elected by the beneficiary will pay from the next day forward through the Medicare intermediary.

After the end of the contract period (i.e., December 31, 2004), MA organizations remaining obligations to CMS include:

(1) Submission of risk adjustment data to CMS. This data will be used to calculate risk-adjusted payments to Medicare Advantage organizations. Therefore, CMS must have all the required historical data for each beneficiary who has been enrolled in a Medicare health plan in order for this data to be accurate. Non-renewing contractors must continue to submit the required hospital inpatient, hospital outpatient and physician risk adjustment for services provided to all its Medicare beneficiaries enrolled during calendar year 2004.

(2) Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the MA contract for the six year period following non-renewal.

(3) Update of plan contact information in HPMS. This will allow CMS to continue to contact appropriate persons in non-renewing Medicare Advantage Organizations until all activity is complete.

(4) Participation in the CMS process to complete final reconciliation of CMS accounts with the Medicare Advantage organizations, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

(5) Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its MA contract was extant.

MA organizations with further questions related to their Medicare contract non-renewals should contact their RO Plan Managers.

PART V. MEDICARE COST PLAN NON-RENEWAL PROCESS FOR 2005

Section 1 –Notices and Letters

Interim Notification Letter - For Medicare Cost Plans giving official notification prior to October 2, 2004.

CMS will strongly encourage a Medicare cost plan to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. Medicare cost plans that use the 2004 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these Medicare cost plans must inform their RO of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

Medicare cost plans that revise the CMS Model Interim Notification Letter must submit their letter to their CMS RO for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than November 2, 2004. CMS strongly encourages Medicare cost plans to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated November 2, 2004 to ensure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that Medicare cost plans must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states include California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. **If there are changes to this list of states with additional protections, CMS will inform all non-renewing Medicare cost plans prior to the time they develop their final notification letter.**

Medicare cost plans may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Medicare cost plans must include a list of remaining Medicare health plans in the final notification letters that will be available to affected beneficiaries as alternative choices in 2005. The list should include those Medicare health plans that have CMS-approved capacity limits. The final notification letter must call special attention to the fact that some Medicare health plans may have a different open enrollment cycle from Medicare cost plans. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

Regional Office Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS ROs prior to release. Medicare cost plans may submit draft copies of their final notification letters to CMS ROs starting September 15, 2004 but no later than October 2, 2004. CMS RO will give priority review to the submitted final notification letter. CMS strongly suggests that Medicare cost plans use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. CMS encourages Medicare cost plans to consider this review period when making plans to meet the November 2, 2004 deadline for delivery of these final notification letters to beneficiaries.

Medigap Information

Non-renewing Medicare cost plans must inform all affected Medicare beneficiaries, including individuals who are eligible for Medicare due to a disability or End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Details on this topic are provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter. If used, this model language will ensure accurate communication of these technical provisions.

Medicare cost plans are required to provide or arrange for supplemental coverage of benefits related to a pre-existing condition with respect to any exclusion period for all Medicare beneficiaries age 65 or older. For beneficiaries under age 65 who are entitled to Medicare due to a disability or End Stage Renal Disease (ESRD), the cost plan must arrange for supplemental coverage if it is available in the marketplace. Please see §1876(c)(3)(F) and under CMS (HCFA) Medicare Cost Plan contract provision, Article IV, General Conditions, item R.

Per CMS regulations, no special provisions need to be made to provide a "Guaranteed Issue" (i.e., no medical screening, or coverage of pre-existing conditions) Medigap policy, if such a policy is not available in the marketplace. If Medigap issuers in a **particular state do not sell Medigap policies to beneficiaries who are eligible for Medicare due to a disability, the Medicare Cost Plan will still need to provide supplemental coverage for pre-existing conditions.**

Under HMO/CMP Manual Section 3004.5(A)(2), Provide Services Directly, it states, "You may directly provide or arrange for the provision of services related to pre-existing conditions with no charge to the beneficiary."

Under the "Medicare cost contract" the Medicare cost plans sign at the inception of their contract, Article IV, General Conditions, (R) it again refers to providing for benefits of pre-existing conditions for " the lesser of six months or the duration of such period."

Per NAIC and HIPAA, the definition of what constitutes a "pre-existing condition" is as follows, "Pre-existing conditions should be limited to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy."

CMS's interpretation is that coverage for pre-existing conditions for the disabled is a requirement whether a disabled beneficiary: 1) applies for and obtains a Medigap policy with a pre-existing condition exclusion; or 2) applies for and is denied coverage under a Medigap policy. Individuals who are eligible for Medicare due to age have similar protections. The beneficiary will still need to be provided coverage for pre-existing conditions, even if the cost plan has to provide such coverage directly. CMS believes that an individual who is eligible for Medicare due to a disability must make an attempt to obtain a Medigap policy before the cost plan can be required to provide coverage directly. The Medicare cost plan will not be required to provide coverage for pre-existing conditions for those members (aged and disabled) who do not seek a Medigap policy.

The coverage of pre-existing conditions is limited to those costs **related to the pre-existing condition** that result in Medicare cost-sharing amounts, such as Part A and B deductibles and coinsurance and excess part B charges, up to the limiting charge.

CMS will allow the Medicare cost plan to require that all disabled members go to the Medicare cost plans' physicians for treatment, during the time the Medicare Cost Plan is providing coverage for the pre-existing condition. The Medicare cost plan must coordinate and track these beneficiaries during the enrollment period and during the time they are receiving services. CMS must be able to track compliance.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing Medicare cost plans in order to choose from broader range of Medigap policies available on a guaranteed issue basis. Medicare cost plans must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made

for a December 31, 2004 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to buy certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at http://www.cms.hhs.gov/manuals/116_mmc/mc86c02.pdf

Public Notice of Non-Renewal

Non-renewing Medicare cost plans must publish a public notice of non-renewal at least 30 days prior to the end of the contract year (i.e., December 2, 2004) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. Medicare cost plans that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these Medicare Cost Plans must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

Medicare cost plans that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages Medicare cost plans to consider this review period when making plans to meet the November 2, 2004 deadline for release of these public notices.

Section 2 - Systems Issues

Non-renewed Contracts

Non-renewing Medicare cost plans should **not** submit disenrollments for any members who will remain in their organization through December 31, 2004. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the Medicare cost plan submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan or Medicare cost plan are placed in Original Medicare in a timely manner.

Non-renewing Medicare cost plans should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the Medicare cost plans receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2004), Medicare cost plans must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December

31, 2004). Therefore, it is important that non-renewing Medicare cost plans submit any final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

Medicare cost plans will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

Service Area Reductions

Medicare cost plans with service area reductions for 2005 must disenroll all members who reside in the non-renewed area or county**.** Medicare cost plans must submit disenrollment records for all affected members no later than their appropriate cut-off date (12/10/2004) in December, the last operating month of their current contracts.

CMS will provide Medicare cost plans with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third week of December 2004, and verify the disenrollments for all submitted members. Medicare cost plans will also receive a separate communication with specific systems instructions from CMS.

Medicare cost plans with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

Section 3 - Other Information

"Close-Out" Information

In the Fall of 2004, CMS will send a "close-out" letter to non-renewing Medicare cost plans with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to ensure that affected beneficiaries experience a smooth transition from membership in the non-renewing Medicare cost plan to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the Medicare cost plan after the last day of its contract.

Non-renewing Medicare cost plans may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract.

If an affected Medicare cost plan member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing Medicare cost plan is responsible for all appropriate costs and/or cost-sharing associated with Part A inpatient hospital services, until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B.

If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing Medicare cost plans will pay appropriate costs and/or cost-sharing associated with the covered charges through the last day of the contract;

Original Medicare or the next Medicare health plan elected by the beneficiary will assume responsibility from the next day forward.

After the end of the contract period (i.e., December 31, 2004), Medicare Cost Plans' remaining obligations to CMS include:

1. Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the Medicare cost plan contract for the six year period following non-renewal or 3 years following the issuance of the Notice of Program Reimbursement (NPR), whichever is later.

2. Update of plan contact information in HPMS, should the Medicare cost plan access HPMS. Should the Medicare Cost Plan not access HPMS, they will be required to keep the appropriate RO informed of contact information. This will allow CMS to continue to contact appropriate persons in non-renewing Medicare cost plans until all activity is complete.

3. Participation in the CMS process to complete final reconciliation of CMS accounts with the Medicare cost plans, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

4. Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its Medicare cost plan contract was extant.

Medicare cost plans with further questions related to their Medicare cost contract non-renewals should contact their RO Plan Managers.

PART VI. LIST OF CONTACTS

ACR worksheet changes: Tanette Downs, 410-786-7616; Frank Szeflinski, 303-844-7119

Calendar/Medicare Prescription Drug Card: Jennifer Shapiro, 410-786-7407

Calendar/Non-renewal processes: Lettica Ramsey, 410-786-5262

Calendar/Renewal Process: Philip Doerr, 410-786-1059

Cost Plan issues: Tanette Downs, 410-786-7616

Cost-sharing guidance: Tony Hausner, 410-786-1093

Drug formulary policy: Tony Hausner, 410-786-1093

Drugs and incident-to physicians' services: Terese Klitenic, 410-786-5942

EGHP Enrollment Reporting by Medicare Advantage Organizations: Kim Miegel, 410-786-3311

Financial Limitation on Rehab Services: Tracey McCutcheon, 410-786-6715

General HPMS Information: Tim Hoogerwerf, 410-786-9962; Kristin Finch 410-786-2873

HIPAA: Yolanda Robinson, 410-786-7627

HPMS Help Desk: 1-800-220-2028 or hpms@nerdvana.fu.com

HPMS Connectivity: Don Freeburger, 410-786-4586

HPMS User IDs and Passwords: Neetu Jhagwani, 410-786-2548

Implementation of Grijalva v. Shalala and Appeals Notices: Chris Gayhead, 410-786-6429

Instructions for Submitting Employer Group Health Plans: Tanette Downs, 410-786-7616; Frank Szeflinski 303-844-7119

Marketing issues: Wendy Burger, 410-786-1566

Medicare Personal Plan Finder Data: Jennifer Johnson, 410-786-0031

***Medicare & You* 2005:** Erin Pressley, 410-786-5569 and Amy Miner, 410-786-5242

MA contract: Christine Perenich, 410-786-2987

MA Plan Renewal Guidelines, General: Rosanna Johnson**,** 410-786-1148

Mid-Year Benefit Enhancements: Yasmin Galvez 410-786-0434; Frank Szeflinski, 303-844-7119

Non-Renewal Process for 2004: Lettica Ramsey, 410-786-5262

Operational Instructions for Completing the Plan Crosswalk: Kim Miegel (enrollment system), 410-786-3311; Randy Brauer 410-786-1618(enrollment issues); Lori Robinson (HPMS plan crosswalk), 410-786-1826; Rosanna Johnson (other issues), 410-786-1148

Optional Supplemental Benefits: Marty Abeln, 410-786-1032

Office of the Actuary's Review of 2005 ACRs: Richard Coyle, 410-786-6393

Partial County Requests: Sid Lindenberg, 410-786-1157

Passive Elections: Danielle Moon, 410-786-5724

PBP changes: Pam Nicholson, 410-786-0263

Provider-Specific Plan Proposals: Rosanna Johnson, 410-786-1148

Redesigned Managed Care System Cutover: Marla Kilbourne, 410-786-7622

Renewal Plan Splits by Optional Supplemental Benefit Choice: Randy Brauer, 410-786-1618

Renewal Plan Splits by Provider Group: Mary McLean, 410-786-7815

Separate PBPs for EGHP B-only waiver members: Tanette Downs, 410-786-7616; Frank Szeflinski, 303-844-7119

Tiered Hospital Benefits: Rosanna Johnson, 410-786-1148